Personal Health History Annual Questionnaire

Date:_____
Name:_____
Age: ____
Health Card & Version Code: _____

Contact Information:
**Email_____
Phone _____
Mail ____ Yes ____No

Medical History:

List your allergies: Drug _____
Food _____
Environmental _____

List your medication & supplements including dose (prescription & over-the-counter):

Medications	DOSE	**Supplements**	DOSE

List any tests done in the past 2 years, date & location (X-ray, U/S, ECG, Mammogram, Pap, blood)
_____

Has your weight increased or decreased in the past year? No ____ Yes ____ amount: ____
List any surgical procedures or diagnostic tests you have had in the past 12 months:
_____
_____

Review of Systems

Cardiovascular History

Over the past year, have you:
Been treated for high blood pressure? No ____ Yes ____ Diet changes? ____ Medication _____
Had blood clots? No ____ Yes____ – where? _____
Had a heart attack? No ____ Yes ____

How often do you exercise each week?

Breast History:

How often do you do Breast self exams? monthly ____ X/year ____ Never_____-why? _____
Date of last mammogram _____
Do you have any new lumps in your breast? No ____ Yes____ - for how long ____
Have you had any discharge from your nipples? No ___Yes____ – (circle) white, clear, red, brown, green
Do you have breast pain? No ____ Yes ____ – describe_____

Menstrual History:
Date of your last menstrual period. _____
How many days does your period usually last? ____ How many days between your period? _____
How many pads or tampons do you use on a heavy day? ____
How much pain do you have with your periods? MILD ____ MODERATE ____ SEVERE ____
Has there been a change in the amount of pain you have? _____

Gynecologic History:
When was your last PAP test? _____
Check any of the following vaginal problems you experience (now or previously):
____ discharge (circle: curdley, white, thick, yellow, green, thin, brown, itchy, burning, odour)
____ pain with intercourse ____ dryness or inability to lubricate ____ sores – describe _____

Comments_____

Sexual History:
Are you currently sexually active? NO ____ YES ____
Current method of contraception _____
Describe any concerns _____

Bowel & Bladder History:
Describe any changes in your bowel or bladder function _____
_____

Emotional History:
Circle any of the following that you are feeling now:
Excessive crying Depression Anxiety Troubles with Sleeping
What would you like to change?
_____

Write a sentence about how you feel most of the time _____

Social History:
Has there been a change in Occupation or marital status? _____
Circle & complete those that apply to you:
Alcohol Caffeine Cannabis Tobacco Drugs _____

Are you smoking cigarettes? No ____ Yes ____ –how much? ____ / day
How much alcohol do you drink? _____

Do you have specific health concerns today ?
_____
_____
_____

_____THIS SECTION to be filled out with your HEALTH CARE PROFESSIONAL_____

Synopsis of Health Concerns	
1.	2.
3.	4.
5.	6.